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MONTANA COMPREHENSIVE HEALTH PLANNING NEWS

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2 Volume 5, Number 2 — January - February, 1974

CHP Staff Aids in Utah 'b' Agency Assessment

State CHP Administrator Robert Johnson; Warren Brass, Coordinator for Areawide Affairs; and Levi Taft, Director North Central Montana Health Planning Council, spent the week of November 26-30 in Salt Lake City conducting an agency assessment of the Great Salt Lake Health Planning Council, a two-county areawide organization representing some 486,000 people.

Staff personnel were part of a six member assessment team that brought experience in areawide, state, regional and federal health planning to the Salt Lake City agency.

Under a program instituted by the Comprehensive Health Planning Service of the Health Resources Administration HEW, all state and areawide CHP organizations in the country must undergo an assessment by June 30, 1974. The program has been designed as a constructive plan to assist the agencies in their effectiveness in key functional areas as a means of strengthening CHP agencies across the country. The assessment program is specifically formulated to help agencies in identifying operational problems and to assist in dealing with these problems.

Johnson, Brass and Taft attended a training seminar in Vancouver, Washington, earlier last fall in preparation for the assessment process. Respectively specializing in the areas of "agency management," "public issue involvement and community participation and education" and "project review." Johnson, Brass and Taft met with and interviewed approximately 60 individuals who had been active in the CHP programs or who had been affected by decisions made by the Great Salt Lake Health Planning Council program.

Other members of the team assessed the Council in terms of health plan development and implementation, studies, planning coordination and data management.

Commenting on the Salt Lake City trip, Administrator Johnson stated, "The assessment process as a whole is a very equitable and beneficial experience; for both the agency being evaluated and for the people doing the evaluation. In that we're not judging the agencies in terms of good or bad performance, they receive the full benefit of an objective observation which attempts to identify strengths as well as weaknesses. It's a peer-group review in which everyone concerned learns something about maximizing the agency contribution to the areawide health planning goals."

"It also puts us in a good position because we now know more about what the assessment process is all about, and we know what to expect when our own agency undergoes assessment next spring," added Warren Brass.

Taking a break from their assessment duties are Levi Taft, Director of the NCMHPC; Bob Johnson, CHP Administrator; and Warren Brass, Coordinator for Areawide Affairs.

Areawides Begin Health Plans

Areawide health planning organizations are just beginning to realize the size of the chunk they have bitten off for themselves as they begin work on their individual areawide comprehensive health plans.

Under the contract agreement reached last July, the areawide organizations agreed to develop a ". . . comprehensive plan for health at the areawide level using narra-

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Areawide Health Plans —

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tive explanation and including normative comparisons and rank ordered lists of health priorities." With the first draft of the plan due for submission to the State CHP Office by January 31, areawide staffs are busy compiling data accumulated via the nominal group sessions and through statistical information provided by the State Agency.

Having assumed the responsibility for outlining the alternative implementation approaches which will have been taken, or might be taken, in order to meet the health needs identified as health priorities, the areawides will have taken on a complex health planning task. Areawide directors and boards are being aided in their efforts to a limited extent by state staff assistance in the form of working meetings. State CHP personnel are attempting to provide as much assistance and direction as is needed and time permits.

Once the first draft of the areawide plan is submitted to the State Office, it will be reviewed and submitted to the areawide organization in rough draft form for comment by February 1. The second and final draft will be resubmitted to the State CHP Office by May 1, 1974, for inclusion within the State Plan for Health.

EHC Voids FY '74 Work Program

In an attempt to aline the Environmental Health Committee of the CHP Advisory Council more closely to the environmental health planning role of Comprehensive Health Planning, the EHC moved on a unanimous vote at its November meeting to void its FY'74 Work Program.

The Environmental Committee has been suffering a variety of illnesses in the recent past, evidenced by low member interest and sparce attendance at its meetings.

Dave Turner, recently assigned staff assistant to the Committee, spent the early part of last summer conducting a critique of the EHC and made a rather critical report to the Committee at the September meeting. Since that report, the Committee members, under the leadership of Chairman Don Pizzini, Great Falls, have expended a great deal of their time re-examining the Committee and its role in environmental planning and particularly as it related to CHP.

Several times during the past few months there seemed to be a consensus that the Committee might in fact have been a supernumerary in the environmental scene of Montana. However, a "pep talk" by Dr. John S. Anderson, Director, Department of Health and Environmental Sciences, and the continued deep-felt concern on the part of individual committee members led to the Committee's attempt to discern a viable role in environmental health planning.

It was finally at the November meeting, during an address by State CHP Administrator Bob Johnson, that the Committee struck upon the notion of becoming involved in the writing of the Environmental Component of the State Plan for Health.

So contrary to previous suggestions that "maybe we ought to let the Committee just die its natural death," the Environmental Health Committee is alive and well. As one Committee member remarked at the conclusion of the last meeting, "and I thought that the Environmental Committee was dead!"

Citizens' Advocate Office Open

Montana residents with questions, complaints and requests for information about state government will be glad to learn that the Citizens' Advocate Office in room 237 of the State Capitol Building is open for business.

By writing, dropping by the office in person, or simply calling their toll-free number (800-332-2272), citizens may contact the citizens' advocate, Kent Kleinkopf, or his assistant, Kathy McGowan, for assistance when they find themselves lost and confused in the maze of bureaus, departments, divisions, boards and councils that is state government.

In operation since last July, the

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South Central Areawide Holds Annual Meeting

The South Central Regional Health Planning Council, Inc. held its annual meeting in Billings on November 8. Following status reports by the Areawide Alcoholism Plan Steering Committee, the Health Training Network Task Force, the Review and Comment Committee and Executive Director James Toner, the SCRHPC Board took affirmative action on proposals relating to membership, role functions, and responsibilities for the agency.

This being the annual meeting, the South Central Areawide held its yearly election with the following results being reported.

Officers: Miriam Sample, President; John Manley, Vice-President; Colvin Agnew, M.D., Vice-President; Kenneth Jacobson, Treasurer; Beatrice Kaasch, R.N., Secretary.

Executive Committee: Miriam Sample; John Manley; Colvin Agnew, M.D.; Kenneth Jacobson; Bea Kaasch, R.N.; Ralph Gildroy; Genevieve Dyche; Art Lamey; Carol Juneau.

New/Continuing Board Members: Genevieve Dyche (cont.); Doleen Lind, R.N. (new); Manuella Mesteth, R.N. (new); Roger Hanson (new); Alma Johnson (new); Ralph Gildroy (new); Robert Holmes (cont.); Gary Bounous (new); Ken Jacobson (new); Carol Juneau (new); Warren Bowman, M.D. (new).

EDITORIAL

The Coming of PSRO's

By DAVE TURNER — Health Planning Assistant, CHP

Much like a continuously quarreling husband and wife who have known for some time that "old Uncle Harry" is coming to live with them, health care providers and consumers are still having their doubts about the scheduled arrival of Professional Standards Review Organizations (PSRO's).

Consumer advocates complain that Public Law 92-603 which establishes PSRO's, requires consumer input only on a statewide PSRO Council, which is only required when three or more PSRO's are formed in a single state. With the small number of physicians in Montana, just over 800, there would probably not be more than two PSRO's formed and no requirement for a state council. This, they say, sets the fox to guarding the chicken coop.

Providers argue that consumer input in the review of professional activity is out of place, since laymen are not competent judges of professional practices. They also point out that economy and quality care in the medical field are often just not compatible.

And so goes the debate, back and forth, and back and forth. Claude E. Welch, M.D., in a recent article in the NEW ENGLAND JOURNAL OF MEDICINE, has written the most objective analysis of the PSRO approach that we have seen. The article, entitled "PSRO's — Problems and Prospect," cites several areas of concern that health care professionals are going to have to face and resolve if PSRO's are to function as expected.

Welch expects establishment of service norms to be difficult, since they must vary among different types of health facilities which have "variable lists of diagnostic and therapeutic procedures deemed acceptable for inclusion." In Montana, outcomes of the Legislative Council/Department of Health and Environmental Sciences study of public health service will likely bear heavily on norms of health care.

Hardware costs in terms of computers and data banks, and operating costs can be expected to be high. "Medical practitioners are in a particularly vulnerable position since the great bulk of available hardware and expertise is in the hands of the Social Security Administration or third-party carriers," according to Dr. Welch. He estimates the total cost of the system of PSRO's " . . . from a few hundred million dollars yearly to about a billion. A report made by Michigan Blue Shield . . . estimates the maximum budget of a single PSRO would be $330,000 yearly."

Finally, Dr. Welch questions whether the PSRO system will be able to maintain confidentiality or withstand political pressures and rivalries. "Petty jealousies could react to the detriment of all," he warns, "medical statesmanship will be essential."

And the consumer advocates are also suspicious. A report issued by the Washington-based Health Research Group in conjunction with the National Urban Coalition Consumer Health Project says the job of a PSRO is to establish, after consultation with its member doctors, standards of care, or norms, for the treatment of different illnesses handled by local doctors. Once these norms are agreed upon, the PSRO can then begin its screening process of claims for payment. "In other words, the PSRO will then compare the type of medical care shown in the Medicare and Medicaid claims submitted by local doctors with the norms established by the PSRO. If the claims show unnecessary service they may be denied payment by the PSRO panel for that medical specialty."

"Denials probably will be rare, however, since rotating panels of PSRO members will conduct the review. Thus a doctor who has difficulty getting a claim approved by his peers will later be in a position to review their work when his turn comes to sit on the panel. This will result in typical medical society backscratching.

"Consumers are completely excluded from any involvement in local PSRO's just as they are excluded from participating in local medical societies. It will still be virtually impossible for the public to know whether a doctor practices poor medicine. In fact, consumers can only get information on a local doctor when he is actually suspended from receiving Medicare and Medicaid (reimbursement) altogether."

But not all the news about PSRO's is bad. A number of major benefits should be provided by a working PSRO system. According to Dr. Welch, perhaps a 20% reduction in costs of hospitalization could be achieved — something that should make consumers quite happy. "Physicians will of necessity become cost conscious," he says, "a feature that at present is woefully lacking . . . sooner or later they will become involved in risk-sharing with the health underwriters."

PSRO s may also give physicians something to cheer about. In addition to providing "an enormous stimulant to medical education," Dr. Welch says, "The PSRO's for the first time would begin to create a single system that is quite in contrast with present disorganized methods.

VIEWS AND COMMENTS ON CHP NEWS WELCOMED. ADDRESS: LETTERS TO THE EDITOR, CHP NEWS, COGSWELL BLDG., HELENA 59601.

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CHP's Vista's On the Job

Four of the five areawide comprehensive health planning organizations have received a much-needed shot in the manpower arm with the addition of VISTA Volunteers to their staff.

In October a State CHP-sponsored VISTA project was approved and eight volunteers assigned. Four of the volunteers were recruited from the national pool and the remainder were locally recruited and are serving in their own communities. Patricia Ulman, supervisor for the project, has tried to assign one nationally recruited volunteer and one locally recruited volunteer to each areawide organization, thereby striking a balance of experience and perspective.

The stated goal of the project is to " . . . increase low-income and minority participation at both the local and state level in health planning matters." The specific intent is to provide additional manpower.

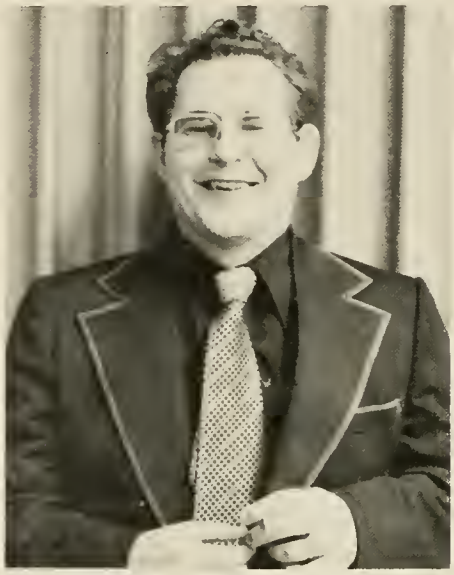
Since their assignment in October, the volunteers have been involved in "outreach" work for the nominal group sessions that have been conducted around the state. Once these meetings have been completed, the volunteers will be engaged in conducting follow-up work that will have been generated by the original nominal group meetings.

Although organizational work will be the vodunteers' principle task, they will also be free to become involved in other health-related projects. Currently, the volunteers assigned to the Southwestern Areawide CHP are working with the Helena Indian Alliance to establish a free health clinic. In the Missoula area, one volunteer is working with the City-County Health Department - sponsored well-child clinic.

The Volunteers In Service To America are proving to be an invaluable aid to CHP in maintaining a sensitivity to the needs of low-income and poverty people. "Their input will probably not be fully realized until long after they will have completed their year of service," remarked Supervisor Ulman.

Mahn Goes West

Taking the advice of Horace Greeley, Edward Mahn, former health planner with the Southwestern Areawide Health Planning Council, has headed west to fill the board-created vacancy as the director of the Missoula-based Northwestern Montana Areawide Health Planning Council.



Edward Mahn, new Executive Director of the Northwestern Montana Areawide Health Planning Council.

A Michigan native, Mahn has worked for the Southwestern Areawide organization as a health planner specializing in facilities review. He was also instrumental in the publication of the **Montana County Profiles,** a statistical analysis of Montana's population, employment, education, housing and ethnic characteristics, which State CHP recently published.

Along with the continuing facility review function, the new director will assume major responsibility for the development of the areawide health plan for the seven counties of northwest Montana.

Ed is a graduate of Grand Valley State College, Allendale, Michigan, and has lived in Montana since being stationed in Havre with the Air Force.

CHP's Little Red Book Now Available

Described as "one successful approach to community health care," Comprehensive Health Planning has just released a little red, eight-page booklet that should be a great aid to Montana communities as they begin to investigate alternatives to their health manpower needs.

Depicting the all too familiar story of a small rural community isolated from physician and medical facility care, the booklet describes how three Montana communities working together solved their mutual problem through use of the Nurse Practitioner approach.

The booklet, entitled "Introducing a Community Nurse Practitioner," provides a brief history of how the various communities went about establishing the Seeley Lake-Ovando-Swan Lake (S.O.S.) Project, along with examples of duties and responsibilities of typical nurse practitioners.

The publication also provides answers to some frequently asked questions about the nurse practitioner approach.

The booklet is available by simply writing the Division of Comprehensive Health Planning, Cogswell Building, Helena 59601.

EHC Elects Chairperson

The Environment Health Committee at its November 13 meeting elected Mrs. Martha Anne Dow as its new chairperson.

Former Chairman Don Pizzini, who has held the post since November, 1972, was forced to resign due to other time commitments relating to his duties as county sanitarian of Cascade County.

Mrs. Dow, a recent appointee to the State CHP Advisory Council and Havre resident, brings a wealth of environmental interest and knowledge to the chair. An active member of the EHC with a lengthy history of involvement in environmental matters, Mrs. Dow is currently employed by Kemdata Laboratory, Havre, where she works in chemical data processing. Martha Anne is a graduate of Montana State University and holds a masters degree in microbiology. She was a former instructor of microbiology at Northern Montana College in Havre.

Hill-Burton "Free Care" Clarified

Almost three decades ago the Congress enacted the Hospital Survey and Construction Act, popularly known as the Hill-Burton Act, to increase the availability of hospital services in the United States. A major portion of that act addressed itself to the problem of lack of available health care services to the indigent.

Under the provisions of the act each hospital facility receiving federal assistance for new construction, alteration, modernization of existing facilities or new additions was required to agree to provide "a reasonable volume of services to persons unable to pay therefor."

Some 26 years after the law's passage, and only after seven law suits were instituted and several court orders directing compliance were ordered, the Department of Health, Education and Welfare finally began implementing the regulations requiring the 3800 hospital grantees and the 50 state agencies administering Hill-Burton funds to see to it that the poor received some hospital services to which they were entitled and so desperately needed.

Even so, change is slow to occur. Jeffrey B. Schwartz, an attorney with the National Health Law Program (NHLP) states, "The inertia of the past has an overriding effect and hospital and state agencies are still not providing the required free services and below cost services to the poor. Such noncompliance is illegal; it should and must be stopped."

Commenting on the law suits against Hill-Burton hospitals and state agencies for failure to carry out their responsibilities, Schwartz says that hospitals use a variety of subterfuges to hide their non-compliance. "Claiming that bad debts are free service to the poor is one such subterfuge. Others are counting services provided in prior years (including so-called Medicaid losses), failure to make prior determinations, and refusing to serve some poor patients free as part of a mix

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WAMI May Ease Manpower Shortage

As the people of small communities and rural areas can tell you, the old addage of "them that has is them that gets" was never more true than when you go out in search of a resident physician.

Historically speaking, Montana's physician shortage has always been a function of maldistribution, not numbers. Today, that problem still exists; those areas that have physicians are the areas that continue to attract even more.

Presently, the state's ratio is approximately one physician for 1000 people; not too bad when one compares it to the national average of 1.5 physicians for 1000 people. However, 46% of Montana's population lives in rural areas, while 85% of her physicians live in urban centers. Twenty-two of Montana's 56 counties have over 1000 people per physician, and 16 counties have over 2000. Six counties have **no** physician in residence. Big Horn County has a ratio of one M.D. for 10,000 people, while Missoula, Lewis & Clark and Yellowstone counties have less than 650 people per physician; a ratio that is more than adequate for good health care.

This maldistribution problem has many roots. One factor is the lack of a medical school in Montana. Prospective students are forced to go out of state and with the increased legislative pressure on most state-supported medical schools to drastically limit the number of positions available to out-of-state students, Montana residents are often refused admission because state applicants are given priority in open slots. With applications running three to one for the limited openings, Montana students have a slim chance of getting into the medical schools.

There is little possibility of Montana constructing its own medical school. The American Association of Medical Colleges estimates the cost of building a facility capable of enrolling 54 students in the $60 to $100 million range, far beyond the capabilities of a rural state like Montana.

The lack of a medical school also adds to the maldistribution problem in that few doctors are willing to practice medicine so far from major medical facilities and resources. Montana's isolation makes continuing education for the physician a big problem. In addition, recent studies have shown that most doctors tend to set up practice where they received their clinical training. No such clinical training facilities have ever been established in Montana.

Adding to the problems of the small community is the question of how to keep a physician once his services have been secured. Several gimicks have been tried by

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"With applications running three to one for the limited openings, Montana students have a slim chance of getting into the medical schools."

WAMI —

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various communities to retain resident physicians but in the end it is a function of how well the M.D. is attuned to the people of the community and their culture that is rural Montana.

In 1971 the University of Washington began an experimental program, the WAMI Program, a new and unique concept in regionalized medical education. WAMI is an acronym for the states of Washington, Alaska, Montana, and Idaho, and WAMI could well mean more general practitioner physicians for Montana.

WAMI has three important goals:

1) *to increase the positions available to regional applicants, while at the same time allaying construction costs by using existing educational facilities in the four-state area;*

2) *to increase the number of practitioners, particularly primary care physicians, in the small community and rural areas by providing clinical experiences through community clerkships in the region;*

3) *to increase the opportunities for continuing medical education through a freer flow of information between the School of Medicine and the region's physicians.*

In order to achieve these goals, WAMI has developed a two-phase program: the university phase and the community clinic phase.

The University Phase was created to admit more students from the "AMI" states to medical school. Under the University Phase of the WAMI Program, Montana students receive the first portion of their medical education at Montana State University. Other students from other WAMI states attend classes at their respective participating universities. Upon completion of the quarter, the students rejoin their class at the School of Medicine in Seattle for the remainder of their medical education.

According to Dr. John Jutila, Coordinator for the Montana WAMI Program, Montana students wishing to attend medical school through participation in the WAMI Program must be residents of Montana, though they need not have attended or graduated from a Montana educational institution. Through particular emphasis placed upon recruiting Montana residents, it is hoped to enroll students who express a desire to become general practitioners and who wish to practice medicine in the small community or rural area.

The fall quarter at MSU, equivalent to the first quarter of studies at the University of Washington School of Medicine, offers a coordinated curriculum of basic sciences as well as a common system of testing and evaluation. MSU provides a core curriculum of epidemiology, biochemistry, anatomy, physiology, pharmacology, and medicine health and society. In addition, each student spends four hours a week with a practicing physician from the Bozeman community.

Future plans call for the University Phase to be extended to a full year so that students will receive their freshman year of medical curriculum at Montana State.

The Community Clinical Phase of WAMI was created in the hope of increasing the number of physicians practicing in rural areas. The Community Clinic Units have been established in all of the four WAMI states. Montana has one such clinic located at Great Falls, in pediatrics. Other units are being planned for the state to include an internal medicine unit in Missoula and/or Billings.

The Community Clinical Units were set up to provide clinical experience in the state of Montana in hopes that students will return to the state to set up practice where they are needed most, i.e., small communities and rural areas. In the local clinics the students are exposed to the practice of medicine in the small town, providing them with first-hand experience upon which to make their own personal decisions regarding where they will eventually practice medicine.

Communities which are the sites of the Community Clinical Units benefit from the experience in that continuing medical education is available through the WAMI Program to the sponsoring physicians.

If the WAMI Program proves to be a success, the state of Montana will soon see more medical school positions being opened for its citizens, the redistribution of health manpower in the state will be underway and the opportunities for continuing health education for her physicians will be greatly increased. Furthermore, it is thought that the benefits to taxpayers, who

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EDAEM Hires Health Planner

Someone once said, "You don't have to have a pretty face to write an areawide health plan, but it sure helps!" Taking the advice of that anonymous sage, the Economic Development Association of Eastern Montana, which has assumed areawide CHP functions for the entire 18-county Eastern Area, has recently enlisted the services of Sandra Nicholson.

Sandy has been hired as a health planner with primary responsibility for research, analysis, development and writing of the Eastern Area Health Plan.

On the job since the first of October, Sandy has been busy meeting with hospital administrators, county commissioners and the Facilities Review Committee of of the Eastern Area in conducting initial research for the plan.

A 1968 graduate of Montana State University, Bozeman, Sandy has taught school and worked for Phillips County as a caseworker in their social services department.

Sandra Nicholson, new health planner for EDAEM, confers with Warren Brass, Planning Coordinator for Areawide Affairs and Dr. Ray Studt, IRMP, at a recent meeting in Billings.

Nixon Signs HMO Bill

President Nixon signed into law on December 29, a $375 million measure designed to encourage the formation of Health Maintenance Organizations. A Health Maintenance Organization, or HMO as it is popularly called, is an organization which assumes responsibility for providing or otherwise assuring the availability of an agreed upon set of comprehensive health maintenance and treatment services for voluntarily enrolled individuals in a defined geographical area. These services are provided for a predetermined and prepaid sum of money from each person or family enrolled in the plan.

The HMO concept, prepaid group medicine, is a carefully designed part of a strategic plan to improve health care in the United States. It was conceived to achieve two primary objectives:

—To make available to most citizens a comprehensive health care program at a prepaid, certain cost; and

—To provide a flexible organizational concept to the physicians which would bring market place incentives to the health care industry.

The goal is to make it worthwhile to the physician to keep his patients as healthy as possible and when they are sick, to treat their illness with the most efficient and economical methods available. Emphasis is placed upon preventive medicine. The HMO concept attempts to align the physician's economic incentives with the consumer.

In addition, the HMO concept was developed in consideration of these other important goals:

—To give the people a choice as to the type of health care system they may use. The HMO is not a panacea but an alternative;

—To bring about greater organizational efficiency;

—To control costs;

—To provide a basis for predicting health care expenditures under government financial programs;

—To provide a mechanism for meeting currently unmet health care needs at predictable cost.

There are already about 115 HMO's in the nation and they serve about 2.5 million people. The passage of the law could lead to establishing about 300 more.

Grants and contracts will be made available to plan and help establish HMO's. There will also be loan guarantees to help the organizations during their early periods of operation.

Monthly premiums among HMO's which are currently operating, range from $14.50 to $21 for an individual and from $34.47 to $53.84 for a family. As with insurance policies, benefits differ in the various HMO packages. The newly passed HMO law defines the basic health services which must be provided to each enrollee by the HMO as:

—Physician services (including consultant and referral services by a physician);

—Inpatient and outpatient hospital services;

—Medically necessary emergency health services;

—Short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

—Medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

—Diagnostic laboratory and diagnostic and therapeutic radiological services;

—Home health services;

—Preventive health services (including voluntary family planning services, infertility services, preventive dental care of children, and children's eye examinations conducted to determine the need for vision correction).

In addition the HMO is required to provide specific supplemental health services to its members if the health manpower required to provide the services is available in the HMO's service area and if the member has contracted for such services. Supplemental health services are defined as:

—Services of facilities for intermediate and long-term care;

—Vision care not included as a required basic health service;

—Dental services not included as a required basic health service;

—Mental health services not included as a required basic health service;

—Long-term physical medicine and rehabilitative services (including physical therapy); and

—The provision of prescription drugs prescribed in the course of the provision by the HMO of a basic or supplemental health service.

Two features of the legislation would be of special interest to Montanans. One is that special appropriations are set aside for feasibility surveys and for planning and development of HMO's in nonmetropolitan areas. The other provision refers to HMO's for Indians and migratory and seasonal workers.

Under the new legislation, in carrying out his functions, responsibilities, authorities, and duties under this Act, the HEW Secretary is authorized, with the consent of the Indian people served, to contract with private or other nonfederal health agencies or organizations for the provision of health services to such people on a fee-for-service basis or on a prepayment or other similar basis.

"The Secretary of HEW, in connection with the existing authority which provides health services to domestic agricultural migratory workers, to persons who perform seasonal agricultural services similar to the services performed by such workers, and to the families of such workers and persons, is also authorized to arrange for the provision of health services to such workers and persons and their families through health maintenance organizations."

The new law permits any HMO for which a grant, contract, loan, or loan guarantee is provided to

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Cost Containment Continues —

1122 REVIEW AND COMMENT: A

Comprehensive Health Planning organizations are frequently called upon by federal agencies to provide the benefit of their thinking on proposed projects that will effect the health of their constituents. Legislated involvement with "1122 Review and Comment" is only one such responsibility of Montana State and Areawide CHP Agencies.

Section 1122, Title XI of the Social Security Act (PL 92-603) which became effective on December 31, 1972, was passed to assure that federal Medicare, Medicaid and Maternal and Child Health funds are not used to support any unnecessary capital expenditures made by or on behalf of a health facility or health maintenance organization. The purpose of the law is to help control rising health costs by discouraging unnecessary health expenditures. The law accomplishes this by permitting the federal government to withhold Medicare, Medicaid and Maternal and Child Health reimbursement for capital expenditures if a facility does not obtain prior approval from the state designated planning agency (DPA). The DPA in Montana is the Department of Health and Environmental Sciences. The coordinating division within the Department is the Division of Hospital and Medical Facilities.

When a health facility decides that it wants to make a capital expenditure which involves $100,000 or more, a change in bed size or a change in service, and for which the facility wishes to get Medicare, Medicaid, or Maternal and Child Health reimbursement, it must submit a proposal to DPA.

As required by the law, the Department takes into consideration the recommendations of the Hill-Burton Agency (Division of Hospital and Medical Facilities), and the State and Areawide Comprehensive Health Planning Agencies when making its determination as to whether or not the proposed capital expenditure is necessary.

The bulk of the work done in Section 1122 Reviews is conducted by the Areawide Comprehensive Health Planning 314(b) Organizations. Committees and their staff gather statistical information which may have a bearing on the proposal, contact administrators of surrounding health facilities and programs to get their opinions on the proposal, and hold a public hearing at which the proposal is reviewed. The areawide organization then forwards its recommendation concerning approval or disapproval of the project to Dr. Anderson, Director of the Department of Health and Environmental Sciences.

NORTHWESTERN MONTANA AREAWIDE HEALTH PLANNING COUNCIL

1. Hamilton
Colonial Manors Corp.
Proposal—to build 40 bed nursing home.
Approximate cost, $851,750.
Disapproved.

2. Plains
Clark Fork Valley Hospital
Proposal—to add 16 skilled nursing beds.
Approximate cost, $120,000.*
Disapproved.

3. Polson
St. Joseph Nursing and Retirement Center
Proposal—to add 16 skilled nursing beds.
Approximate cost, $40,000*
Approved.

SOUTHWESTERN MONTANA AREAWIDE HEALTH PLANNING COUNCIL

1. Big Sky
Orthopedic Associates, P.S.C.
Proposal—outpatient medical clinic.
Approximate cost, $250,000.
Approved.

2. Helena
B & T Management Services, Inc.
Proposal—renovation of the St. John's Hospital building to a 125 bed nursing home.
Approximate cost, $1,075,000.*
Disapproved.

3. Helena
Colonial Manors of Helena
Proposal—build 60 bed nursing home.
Approximate cost, $708,000.
Approved.

4. Helena
St. Peter's Hospital
Proposal—expansion of several services due to the closure of St. John's Hospital.
Approximate cost, $265,153.*
Approved.

5. Livingston
Mr. Edward Boehm
Proposal—to build 85 bed nursing home.
Approximate cost, $1,500,000.
Approved.

6. Livingston
Friendship Manors, Inc.
Proposal—to build a 65 bed nursing home.
Approximate cost, $450,000.
Disapproved.

7. Livingston
Herman, Hauck and Associates
Proposal—to build 104 bed nursing home.
Approximate cost, $1,000,000.
Disapproved

8. Livingston
Livingston Memorial Hospital
Proposal—modernization and remodeling.
Approximate cost, $303,000.*
Approved.

9. White Sulphur Springs
Mountainview Memorial Hospital
Proposal—add 32 nursing home beds.
Approximate cost, $425,000.*
Approved.

SOUTH CENTRAL MONTANA REGIONAL HEALTH PLANNING COUNCIL

1. Billings
St. John's Lutheran Home
Proposal—90 bed long-term
Approximate cost, $1,250,000.*
Approved.

2. Billings
Colonial Manors, Corp.
Proposal—65 bed nursing home.
Approximate cost, $655,550.
Disapproved.

N ON-GOING FUNCTION OF CHP

Within a specified time period, usually sixty days, a review will have been conducted by the area-wide CHP organization and the DPA will have received their recommendation, the recommendations of the Division of Comprehensive Health Planning and the Division of Hospital and Medical Facilities. The DPA then makes a decision regarding the proposal. If the proposal is disapproved, the applicant may appeal the decision to the Board of Health and Environmental Sciences. Appeals to the Secretary of the U.S. Department of Health, Education and Welfare and through the court system are also possible.

Section 1122 does not keep unnecessary facilities from being built or services from being offered. It only affects those that use Medicare, Medicaid, and Maternal and Child Health funds. It is now possible for a hospital in a city with another hospital already offering a sophisticated service to also start offering the same service and use it for private pay patients. If the service is then not utilized to its fullest capacity, the cost of that service will be unnecessarily high. It is nearly as expensive to operate an empty bed or an unused service because of staffing and fixed costs. Only by passing the Certificate of Need Bill drafted by the Division of Hospital and Medical Facilities, which will be introduced during this legislative session, will all such unnecessary duplication of services be stopped. The proposed Certificate of Need Bill has been endorsed by the Montana Advisory Council for CHP.

It is impossible to determine the amount of money saved as a result of doing the reviews. The involvement of Comprehensive Health Planning in the reviews has encouraged facilities to consider sharing services and to refrain from offering services that are not needed. While a figure could be approximated for the amount saved by the disapproval of certain projects, it is impossible to determine exactly how much the prospect of a review may have influenced applicants to omit what would have been a duplication of services from their proposals.

The law states that the DPA and the CHP Organization will receive reimbursement for staff time spent on Section 1122 Review and Comment, and although it is estimated that 20% of the CHP staff time is expended on this function, no monies have yet been received.

Printed below is a breakdown of the 32 proposals valued at $22,-482,787 reviewed by CHP during 1973.

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3. Billings
Hauck and Associates
Proposal—90 bed nursing home.
Approximate cost, $1,300,000.
Approved.

4. Billings
Hauck and Associates
Proposal—cancer treatment center in conjunction with 90 bed nursing home.
Approximate cost, $1,750,000.*
Approved.

5. Big Timber
Pioneer Nursing Home
Proposal—add 16 beds
Approximate cost, $131,000.*
Approved.

EASTERN MONTANA
(Reviewed by State Health Facilities Committee)

1. Glendive
Hauck and Associates
Proposal—104 bed nursing home.
Approximate cost, $1,250,000.
Disapproved.

2. Glendive
Glendive Community Hospital
Proposal—90 bed nursing home. (replacement and addition)
Approximate cost, $1,200,000.*
Approved.

3. Circle
McConha, Inc.
Proposal—24 bed nursing home.
Approximate cost, $410,000.
Disapproved.

4. Glasgow
Valley View Home
Proposal—30 bed addition.
Approximate cost, $419,680.*
Approved.

5. Glasgow
Frances Mahon Deaconess Hospital
Proposal—replacement of existing hospital and nursing home.
Approximate cost, $217,500.
Approved.

6. Culbertson
Roosevelt Memorial Hospital
Proposal—replacement of existing hospital and addition of 40 bed nursing home.
Approximate cost, $842,004.
Approved.

7. Miles City
Holy Rosary Hospital
Proposal—change of service, 10 hospital beds to be relicensed to 10 skilled nursing beds.
Approximate cost, $500.*
Approved.

NORTH CENTRAL MONTANA AREAWIDE HEALTH PLANNING COUNCIL

1. Chester
Liberty County Hospital
Proposal—to replace their existing facility.
Approximate cost, $400,000.
Approved.

2. Cut Bank
Cut Bank-Glacier County Development Company.
Proposal—to construct a professional office building—primarily a doctor's clinic.
Approximate cost, $150,000.
Approved.

3. Great Falls
Rainbow Falls Convalescent Center.
Proposal—to build 120 bed skilled nursing home.
Approximate cost, $1,545,650.
Approved (the DPA approved 100 beds).

4. Great Falls
Deaconess Hospital
Proposal—Ambulatory out-patient service.
Approximate cost, $204,000.*
Approved.

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RHA Draws Growing Attention

A growing interest is developing in the Congress on what its future stance will be regarding three key health programs: Comprehensive Health Planning, Regional Medical Programs, and Hill-Burton. In that CHP and RMP programs have been extended only until June 30, 1974, and that Hill-Burton funds have been impounded, Congress has been considering several varied approaches to the issue.

One approach that is currently being considered would combine the activities of all three programs under one agency. The Regional Health Authority (RHA) concept, sponsored by Representative William Roy (D-Kansas), would place responsibility for planning resource allocation and legislative control of the health system of a given area on a single authority.

The issues surrounding the passage of RHA legislation or some other similar plan would have rather extensive impact on the delivery of health care in Montana.

Under Congressman Roy's draft bill, one RHA would be established to handle the health system of Montana. In more populated states, more than one RHA could be set up in any one state.

Constituted as a private, nonprofit entity independent of all organizations, each RHA would be governed by a council consisting of between 10 and 30 members: ⅓ consumer, ⅓ providers and payors, and ⅓ governmental officials.

The purpose of the council would be to review long and short-range plans of the RHA, as well as approve the budget and review grants approved by the Authority.

With support of an annual federal appropriation authorization, the RHA's would provide financial support and assistance to individuals, organizations, and institutions within their region. These funds may be used for capital construction or "seed monies" for other purposes, however, they may not be used for individual health care services.

Under the draft bill, Montana might receive a 1.4 million dollar annual budget depending upon its rating in an annual and tri-annual review process.

In an attempt to consolidate scattered authority, the bill would place responsibility for certification of health care institutions with the RHA's and would also hold them accountable for cost containment, quality, and availability of the health care institution services within their regions.

With authority to review all capital expenditures in excess of $100,000, as well as the authority to review and approve the annual budgets of all health institutions within the region, the RHA's would have a strong hold on the strings of the health care purse. Reportedly, they might be granted the authority to approve the charges for health services, i.e., rate setting.

In addition, the Regional Health Authorities would have the authority to review and approve all requests for federal funds for health services development with the accompanying power to veto these programs.

Representative Roy's approach would further require that all health care institution insurers be certified. In states already having such procedures, the RHA would accept this certification. In states not having such a procedure, the RHA would establish one. Insurers would not be permitted to make payments for services on the part of the institution which was constructed as unapproved by the RHA, nor could it pay for the services provided in any part of the facility when the institution was not certified by the RHA.

The state's role in the draft bill is one of coordinator in which one designated state agency would have the job of insuring that all programs undertaken by the state were coordinated with the RHA and vice versa.

The federal government will take a bigger hand in the management of things with the Department of Health, Education and Welfare acting as the designating agency in establishing the Health Regions. Once DHEW establishes the regions, it will receive and approve applications for RHA's and also act to review all yearly RHA budgets. At least once every three years each RHA would have to be recertified by HEW to continue operations.

DHEW would provide some assistance in developing RHA's by granting up to $250,000 per year, not to exceed two years. A portion of this sum would probably be used to collect extensive information on health status, health manpower utilization and other health care data which would be made available to the federal government on a regular basis. A variety of guidelines would be provided by DHEW in the development by each RHA of long and short-range goals, establishing need for institutional care and other guidelines to determine the supply of health care.

It should be noted that Congressional members of the House and Senate subcommittees on health are considering several pieces of legislation similar to Roy's Regional Health Authority proposal. It is too early at this point to determine what course Congress is going to take in the health care maze, but health care planners, providers and consumers can rest assured that the future will bring a significantly more closely coordinated health care system.

1122 REVIEW

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5. Great Falls
Columbus Hospital.
Proposal—renovation of current emergency room facilities.
Approximate cost, $84,000.*
Approved.

6. Havre
Hi-line Home 22 Intermediate Care.
Proposal—additional beds and modernize 18 beds.
Approximate cost, $400,000.*
Approved.

7. Havre
Dave Sande and Wilbur Scheresky.
Proposal—60 bed nursing home.
Approximate cost, $425,000.
Approved.

8. Lewistown
Central Montana Medical Facilities, Inc.
Proposal—a new facility with 47 hospital beds and 70 long-term care beds.
Approximate cost, $2,860,000.
Approved.

* **Includes remodeling, etc.**

Comings and Goings at CHP

In response to the increasing role of CHP in the Montana health scene, health planning assistant Dave Turner has been added to the ranks of the state CHP staff. A former VISTA Volunteer, Dave began work with the Department of Health and Environmental Sciences on November 1st. Assigned as a VISTA to CHP since June, he has been working with the Advisory Council's Environmental Health Committee, as well as with the North Central Montana Health Planning Council's Environmental Committee.

Dave and his wife Mary most recently lived in Iowa where the couple graduated from Iowa State University. They moved to Montana early this summer to accept VISTA assignments with the Montana State Economic Opportunity Office.

Staff responsibilities for the new health planning assistant include assisting in the development of the State Comprehensive Health Plan and editing the **CHP News**. Dave will also continue to provide staff assistance to the Environmental Committee.

DAVE TURNER

CITIZENS—

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Citizens' Advocate Office was established by Governor Tom Judge as an alternative to an ombudsman bill which was before the legislature last session.

Receiving 20-30 calls per day, the office has been termed a success thus far by the staff. The office handles all sorts of inquiries, with the exception of legal questions, about state government.

Finding answers to citizens' questions may sometimes require extensive research on the part of the citizens' advocate office, or may necessitate a direct reply from an authority in state government on the subject in question.

The office is open from 8 a.m. to 5 p.m., Monday through Friday, and interested persons in need of assistance are encouraged to call to find out about the workings of Montana state government.

Busy answering all sorts of questions, the Citizen's Advocate Office is open for business!

EDAEM Selects Board

The Economic Development Association of Eastern Montana, which performs the CHP function of the eastern areawide, selected its Facilities Review Board members recently and held an orientation session for the new board members on December 3 and 4.

Chosen to represent the 18 counties of eastern Montana were: Jim Schumacher, Malta; Ernie Logan, Glasgow; Lyder Tande, Scobey; Dr. Messinger, Plentywood; Patricia Peterson, Culbertson; Margaret Gannon, Wibaux; Myron Ernst, Circle; Dr. Leroy Moline, Glendive; Mary Alice Rehbein, Sidney; Margaret O'Connor, Jordan; Jim Hoffman, Glendive; Ray Frank, Terry; Dirk Rolston, Miles City; Frances Groskey, Miles City; Minnaclare Lavender, Baker; Alyce Kerr, Forsyth; Floyd Irion, Broadus; Viola Sandy, Ekalaka; and Lucy Hope, Hysham.

WAMI—

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might otherwise find it necessary to build a Montana medical school, will be substantial.

But everything has its price. If the goals of the program are to be accomplished, the individual states participating in the WAMI Program must assume some financial responsibility. The original financing of the program came from a combination of private institution and federal funding. That funding is scheduled to end entirely by June, 1975. It is estimated that the state of Montana must contribute approximately $250,000 per year to fund the Montana WAMI Program. This figure is based on 15-20 students at 10-12 thousand dollars per student.

So it appears as though the Montana Legislature holds the future of the WAMI Program in its hands. Their decision to fund or not fund the program may have a large bearing on the success of small communities and rural areas searching for resident physicians as well.

HMO—

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operate in a state regardless of certain restrictive provisions in a state's laws. This provision would knock out laws now on the books in 22 states, including Montana, which in some way may hamper development of such plans.

During the first session of the 43rd Legislative Assembly of Montana, Senator Gordon Bollinger introduced SJR 34 which requested the Legislative Council to conduct a feasibility study of health maintenance organizations for Montana. Although the resolution was passed by both houses of the legislature and signed on March 15, 1973 by Governor Thomas Judge, the study has not been undertaken by the Legislative Council. Limited staff resources to conduct a proper study of HMO's has been cited as the reason the Legislative Council did not begin the SJR 34 study. With the signing of the national HMO legislation by President Nixon, funds are now available to conduct feasibility studies or to develop the HMO concept in Montana.

Hill-Burton —

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with below cost care. All these practices are improper."

Montana became the first state in the nation to draft Hill-Burton regulations clarifying the "free service" requirements. Mr. Wallace King's Bureau of Construction, under the DH&ES' Division of Hospitals and Facilities, is the agency charged with administration of Hill-Burton funds at the state level.

Under the new state regulations, effective August 7, 1972, Hill-Burton grantees are given three options for insuring compliance for providing "a reasonable volume of services to persons unable to pay." Under the "presumptive compliance" section of federal and state regulations, Hill-Burton hospitals must provide "uncompensated services" at a level of either: not less than the lesser of 3% of the annual operating costs minus Medicare and Medicaid reimbursement, or 10% of all the federal assistance received each year (for 20 years following construction in cases of grants, or for the period of the loan or interest subsidy). A third option provides that they may certify that they will not exclude any person from admission because he is unable to pay and that services provided by the facility will be made available without charge, or at a charge below the reasonable cost of the services.

"The inertia of the past has an overriding effect, and hospital and state agencies are still not providing the required free services and below cost services to the poor."

Montana regulations further require that Hill-Burton grantees "will prominently display in the admitting area a sign stating the option selected by the facility and the availability of the criteria."

To date, 38 hospital facilities in Montana have received in excess of $18 million in federal assistance under the Hill-Burton Act. Noncompliance with the regulations has not been a major problem with Montana facilities, according to King's office.

By carrying out the Congressional mandate that public resources be used to stimulate hospital construction and that part of those resources act as a subsidy for care of the indigent, the potential of the Hill-Burton Act to significantly increase the health services provided to the poor seems to have been realized in Montana. However, Hill-Burton facilities still have a long way to go toward fulfilling their obligations as evidenced by the findings of the Low-Income Health Task Force Study which revealed the unavailability of health services as a priority problem facing poor people of Montana.

The future calls for a greater degree of voluntary compliance with the spirit of the Hill-Burton Act in order that all Montana citizens may receive the necessary hospital care to which they are entitled. Any facility requiring further information concerning Hill-Burton regulations is encouraged to contact Mr. King's office in Helena.

NO STRING . . . NO SING

The State Department of Health's musical entry in the "things-that-hurt-my-ears-the-worst" contest, The Twenty-third Inspirational Jug Band, may hit a few sour notes as a direct consequence of the national shortage of petroleum-derived products.

It is reported that washtub-base player, Dave Turner, has threatened to quit the Jug Band unless steps are taken immediately to alleviate the shortage of petroleum from which base strings are made.

It seems as though the Jug Band has been trying to live with the crisis, however, the strain is beginning to show. It is alleged that the band played at the Department's Christmas Party using "plain ole clotheline rope" for base string. According to Turner, no one in the audience seemed to notice. "Musta been them acoustics," he remarked after the performance.

The jug sits idle while CHP staff members deal with the energy crisis.

Fiddler Mary Jane Crigler, spokeswoman for the band, claimed, "The band is really strung-out over this thing and there's talk of boycotting the '76 Inaugural Ball unless we can get a line on this shortage thing!"

Interviewed while dashing off telegrams to key political figures, Turner stated, "Unless the washtub-base players and all them other musical professionals band together we're in for a real thumpin'!"